GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 21, 2026

Lisa Springett
30744 White Oak Drive
Bangor, MI 49013

RE: License #: AS800379702
Investigation #: 2026A1031030
Engedi AFC

Dear Ms. Springett:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

If you desire technical assistance in addressing these issues, please feel free to contact me. In any event, the corrective action plan is due within 15 days. Failure to submit an acceptable corrective action plan will result in disciplinary action.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

Sincerely,

KDuda

Kristy Duda, Licensing Consultant
Bureau of Community and Health Systems
350 Ottawa, N.W. Unit 13, 7th Floor
Grand Rapids, MI 49503

enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT

I. IDENTIFYING INFORMATION

License #:	AS800379702
Investigation #:	2026A1031030
Complaint Receipt Date:	06/24/2026
Investigation Initiation Date:	06/24/2026
Report Due Date:	08/23/2026
Licensee Name:	Lisa Springett
Licensee Address:	30744 White Oak Drive Bangor, MI 49013
Licensee Telephone #:	(269) 217-9359
Name of Facility:	Engedi AFC
Facility Address:	12 E. Arlington Bangor, MI 49013
Facility Telephone #:	(296) 427-5879
Original Issuance Date:	01/06/2016
License Status:	REGULAR
Effective Date:	07/06/2024
Expiration Date:	07/05/2026
Capacity:	5
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Residents did not have access to the bathroom due to staff locking it.	Yes
Staff slept in a resident's bed when they were gone for the weekend.	Yes

III. METHODOLOGY

06/24/2026	Special Investigation Intake 2026A1031030
06/24/2026	Special Investigation Initiated – Telephone Interview with Candice Kinzler.
06/26/2026	Inspection Completed On-site
06/26/2026	Contact - Face to Face Interview with Resident A, Resident B, and Lisa Springett.
07/13/2026	Contact - Telephone Interview with Lindsay Hall, Miranda Tillery, and Lisa Springett.
08/21/2026	Exit Conference held with Lisa Springett.

ALLEGATION:

Residents did not have access to the bathroom due to staff locking it.

INVESTIGATION:

On 6/24/26, I received a telephone call from Van Buren recipient rights director Candice Kinzler. Ms. Kinzler reported she received a complaint that read staff were locking the bathroom door at night to prevent a resident from having access.

On 6/26/26, I conducted an onsite inspection at the facility and interviewed Resident A, Resident B, and Lisa Springett.

Resident A and Resident B were both consistent in reporting that direct care worker (DCW) Lindsay Hall locked the bathroom door at night to prevent Resident C from

going into the bathroom. They reported she does this because Resident C likes to flush things down the toilet and it gets clogged.

Ms. Springett reported she was informed that a staff member had locked the door. Ms. Springett reported she addressed this with staff, and they reported Resident C locked the door himself. Ms. Springett reported the doorknob was changed to a nonlocking against egress doorknob to prevent the door from locking from the inside. Ms. Springett reported there is a key for the door to access it from the outside when needed.

On 7/13/26, I interviewed Lindsay Hall, Miranda Tillery, and Lisa Springett via telephone.

Ms. Hall reported there were occasions when Resident C locked the door and she was not aware that they had locked it. When residents informed her, the door was locked, she unlocked it. Ms. Hall reported she was told by other staff and the licensee to lock the door at night to prevent Resident C from flushing objects down the toilet. Ms. Hall reported Resident C has clogged the toilet on multiple occasions by flushing objects down the toilet.

Ms. Tillery reported she does not lock the bathroom door when she is working. Ms. Tillery reported she was informed by residents that Ms. Hall locks the bathroom door at night. Ms. Tillery reported that Ms. Hall works independently on overnight shifts, so she has not witnessed the door being locked.

Ms. Springett reported she never directed staff to lock the door. Ms. Springett is aware of Resident C's behaviors and encourages staff to monitor him as needed if he brings items into the bathroom.

APPLICABLE RULE	
R 400.641	**Resident behavior interventions.**
	(6) A licensee, staff, volunteers, or any person who lives in the facility shall not do any of the following: **(e) Withhold food, water, clothing, rest, or toilet use.**
ANALYSIS:	There was sufficient evidence found to support the fact that staff were locking the bathroom door to prevent Resident C from having access to the toilet.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Staff slept in a resident's bed when they were gone for the weekend.

INVESTIGATION:

Ms. Kinzler reported she received a complaint that read staff slept in the spare bed located in Resident D's room while she was away with family for a weekend.

Resident A and Resident B reported someone did sleep in Resident D's bedroom while she was not at the facility.

Ms. Hall reported when Resident D was away at a camp for the weekend, she did have her daughter spend the night at the facility when she was working. Ms. Hall reported her daughter did sleep in Resident D's bedroom. Ms. Hall reported Ms. Springett informed her that she is allowed to have her daughter stay with her at times when she is working overnight shifts.

Ms. Tillery reported she thought someone had slept in the spare bed in Resident D's bedroom because there were pajamas, a charging cord and a fan set up in the bedroom.

Ms. Springett reported she did inform Ms. Hall that she could bring her daughter to the facility to spend the night while she works as she encourages a family environment. Ms. Springett reported there is a bed in the basement to be used, not a resident bedroom.

APPLICABLE RULE	
R 400.681	**Resident rights; licensee responsibilities.**
	(3) A licensee and staff shall respect and safeguard all of the following resident rights to: **(p) Be treated with consideration and respect with due recognition of personal dignity, individuality, and need for privacy.**
ANALYSIS:	Staff did not ensure Resident D's need for privacy as Ms. Hall admitted allowing her daughter to sleep in Resident D's bedroom while she was away for the weekend.
CONCLUSION:	**VIOLATION ESTABLISHED**

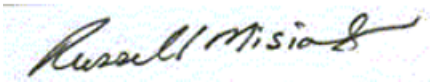
IV. RECOMMENDATION

Upon receipt of an acceptable corrective action plan, it is recommended that the status of the license remain unchanged.

8/20/26

Kristy Duda — Date
Licensing Consultant

Approved By:



8/20/26

Russell B. Misiak — Date
Area Manager